E. Subpart E--State Plan Requirements: Enrollee Financial Responsibilities

1. Basis, scope, and applicability (§457.500).

A State that implements a separate child health program may impose cost-sharing charges on enrollees. A State that chooses to impose cost-sharing charges on enrollees must meet the requirements described in section 2103(e) of the Act. In proposed §457.500, we set forth section 2103(e) of the Act as the statutory basis for this subpart, containing cost-sharing provisions. As proposed, this subpart consists of provisions relating to the imposition under a separate child health program of cost-sharing charges including enrollment fees, premiums, deductibles, coinsurance, copayments, and similar cost-sharing charges. We proposed that these provisions apply to all separate child health programs regardless of the type of coverage (benchmark, benchmark equivalent, Secretary-approved or existing comprehensive State-based coverage) provided through the program.

We noted in the preamble that these requirements apply when a State with a separate child health program purchases family coverage for the targeted low-income child under the waiver authority of section 2105(c)(3) of the Act and proposed §457.1010 and when a State provides premium assistance for coverage under a group health plan as defined in §457.10. We proposed that this subpart does not apply to Medicaid expansion programs. In this

final rule, we revised the statutory basis at §457.500(a) to include section 2101(a) of the Act, which describes that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Comment: A number of commenters noted that the numerous protections written into the Medicaid statute were not written into the SCHIP statute because Congress clearly recognized that these populations are different and intended that they be treated differently. The commenters noted that cost-sharing gives working families a sense of pride in sharing the cost of medical services, just like their friends, neighbors, and relatives who have employer-based insurance. They also indicated that asking families to track their own cost-sharing expenditures contributes to the development of self-sufficiency. Some commenters noted that establishing low levels of cost-sharing will encourage substitution of coverage.

Response: We have implemented §§457.500 through 457.570 of the final regulation under the authority of section 2103(e) of the Act. Congress included cost-sharing protections for children covered under SCHIP through separate child health programs, in recognition of the important role that affordability plays in determining whether a child has access to health care insurance

and essential health care services for their families. High cost-sharing charges could result in low-income families choosing to remain uninsured, dropping insurance coverage, or avoiding utilization of necessary health care services. Increased cost sharing may also encourage enrollees to access health care only during times when care is most expensive (that is, during emergency or critical health care situations). We have retained States' ability to rely on a methodology for tracking cost sharing that places some of the responsibility on the enrollee. As noted in the preamble to the proposed rule, we do, however, encourage the use of more formal tracking mechanisms that ease any tracking or administrative burden on enrollees and providers, such as a swipe card. While we recognize that low levels of cost sharing may encourage substitution, States must meet the requirements in subpart H, Substitution of Coverage, that are intended to limit the occurrence of substitution.

Comment: One commenter suggested that HCFA revise this section to apply the SCHIP copayment rules to Medicaid expansion programs, not just separate child health plans. The commenter believed that this revision would effectuate Congressional intent, which was to allow States flexibility in implementing SCHIP plans.

Response: Section 2103(e)(4) of the Act provides that the cost-sharing requirements and limitations established pursuant to

section 2103(e) do not affect the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in a Medicaid expansion program under section 2101(a)(2). Therefore, Congress has made it clear that these cost-sharing provisions were intended to apply to separate child health assistance programs only. The title XIX cost-sharing rules apply to Medicaid expansion programs, and these rules generally prohibit cost sharing for children. Therefore, the reference to Medicaid expansion programs in §457.500(c) has been removed.

Comment: One commenter recommended that we include language in the preamble advising States that they must ensure that cost-sharing requirements are administratively workable and not unduly burdensome for managed care entities.

Response: We agree with the commenter. States should strive to impose cost-sharing charges in a manner that eases administrative burden on managed care entities and their participating providers and thereby promotes provider participation in SCHIP. We believe the cost-sharing provisions in §§457.500 through 457.570 of this final rule provide States with flexibility to use a variety of strategies to implement these requirements while at the same time providing enrollees with important protections.

2. General State plan requirements (§457.505).

Section 2103(e)(1)(A) of the Act specifies that a State plan

must include a description of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Section 2103(e)(1)(A) also specifies that any such charges be imposed pursuant to a public schedule. In accordance with the statute, at §457.505, we proposed that the State plan must include a description of the amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed. We further proposed that the State plan include a description of the methods, including the public schedule, the State uses to inform enrollees, applicants, providers, and the general public of the cost-sharing charges, the cumulative cost-sharing maximum, and any changes to these amounts.

We also proposed that States that purchase family coverage or offer premium assistance programs must describe how they ensure that enrollees are not charged for copayments, coinsurance, deductibles, or similar fees for well-baby and well-child care services and that they do not charge American Indian/Alaska Native (AI/AN) children cost sharing. We also proposed that a procedure that primarily relies on a refund given by the State to implement the requirements of this subpart is not an acceptable procedure. We proposed that in States that purchase family coverage or establish premium assistance programs, the State also must describe in its State plan the procedures used to ensure that enrollees are not charged cost

sharing over the cumulative cost-sharing maximums proposed in §457.560. We emphasized that this process must not primarily rely on a refund for cost sharing paid in excess of the cumulative cost-sharing maximum. In §457.505, we have added a paragraph (c) that will require States to include in the State plan a description of the disenrollment protections required under §457.570. We have also added paragraph (e) in this section to reduce redundancy and more clearly identify the State plan requirements when a State uses a premium assistance program.

Comment: Several commenters did not agree with the statement in the preamble that suggested that providers could bill the State directly, so that enrollees are not inappropriately charged for certain services. They noted that many health plans are not willing to make the administrative changes necessary to bill the State agency instead of the enrollee and, in light of the difficulties, proposed that a refund component be a valid option.

Response: We disagree. States should establish adequate procedures to ensure the requirements for cost-sharing charges are met and to educate both the provider and the enrollee regarding cost-sharing obligations. Having providers bill the State directly is one option States may use as part of these procedures. We also note that we have not prohibited the use of refunds in all circumstances, but we do require that a State not

use a refund as the primary method for assuring compliance with cost-sharing prohibitions and cumulative cost-sharing maximums. Other examples of tracking procedures include informing enrollees that they are approaching the cumulative cost-sharing maximum right before the cap is reached, or sending monthly letters to providers to inform them of which enrollees do not need to pay copayment amounts as of a certain date. We have revised proposed section §457.505(d) to clarify that when States provide premium assistance for group health plans, cost-sharing charges are not permitted for well-baby and well-child care services; cost sharing is not permitted for AI/AN children; and enrollees must not be charged cost sharing that exceeds the cumulative cost-sharing maximum. These provisions must be described in the State plan. Finally, the provision specifying that "a procedure that primarily relies on a refund given by the State for overpayment by an enrollee is not an acceptable procedure for purposes of this subpart" has been moved to §457.505(e) for clarity.

Comment: One commenter suggested that we define the word "primarily" as used in §457.560 for a variety of situations. For example, they indicated that a State may not be able to ascertain at the time of eligibility determination whether an applicant is an AI/AN due to the lack of verification of AI/AN status on the part of the applicant and/or the lack of cooperation in verification on the part of the tribe. In this situation, the

State may not waive cost-sharing charges for the individual and, in their view, the only way a State could comply with the requirement that the AI/AN population be excluded from cost sharing would be to use a procedure of refunds for overpayments, once AI/AN status was verified.

Response: We realize that there may be unforeseen circumstances when an enrollee has paid cost sharing that either should not have ever been charged or is in excess of the cost-sharing limits. In these cases, refunds will be necessary. However, refunds should not be the State's only or ongoing method to ensure that cost sharing does not exceed the regulatory limits. The State should inform each enrollee of the precise amount of the cumulative cost-sharing maximum based on the enrollee's individual family income at the time of enrollment and/or reenrollment or, in the case of a set out-of-pocket cap, inform the enrollee of cost sharing as required under §457.525. Rather than rely on a refund mechanism, the State should educate the enrollee regarding the cumulative cost-sharing maximum and when not to pay cost sharing for the applicable time period. In the case of the AI/AN population, States should provide accessible information to the population about the State requirements for demonstrating AI/AN status and, as in other instances, seek to minimize the use of refunds as a method for compliance with the cost-sharing requirements of Subpart E.

3. Premiums, enrollment fees, or similar fees: State plan requirements (§457.510).

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed pursuant to a public schedule. At §457.510 we proposed that when a State imposes premiums, enrollment fees, or similar fees on SCHIP enrollees, the State plan must describe the amount of the premium, enrollment fee, or similar fee, the time period for which the charge is imposed, and the group or groups that are subject to these cost-sharing charges. We also proposed that the State plan include a description of the consequences for an enrollee who does not pay a required charge. We noted in the preamble that the State should indicate enrollee groups that are exempt from any disenrollment policy.

In addition, proposed §457.510 set forth the requirement that the State plan include a description of the methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in proposed §457.560, pursuant to section 2103(e)(3)(B) of the Act. We noted in the preamble to the proposed rule that the State's methodology should include a refund for an enrollee who accidentally pays more than his or her cumulative cost-sharing maximum. We proposed that a methodology that primarily relies on a refund by

the State for cost-sharing payments made over the cumulative cost-sharing maximum will not be an acceptable methodology.

We discussed the findings of the George Washington University study on the types of methods States and private insurance companies use to track cost-sharing amounts against an enrollee's out-of-pocket expenditure cap. We described several examples of methods States could use to ensure that enrollees do not exceed the cumulative cost-sharing maximum. We solicited comments on tracking mechanisms States can use that do not place the burden of tracking cost-sharing charges on the enrollee.

Comment: Two commenters specifically urged HCFA to encourage States to adopt cost-sharing provisions for premiums, enrollment fees, and similar fees, as opposed to cost-sharing charges related to the provision of services (copayments, coinsurance, deductibles, or similar cost-sharing charges). The commenter asserted that applying cost sharing to premiums instead of services would avoid the tracking burden altogether.

Response: We agree that it would be easier to track cost sharing if the State only imposed premiums or enrollment fees and that this would relieve States from the burden of tracking cost sharing associated with services. However, the statute provides States with flexibility to design cost sharing that meets their policy goals. While some States may wish to design cost sharing in a way that avoids or minimizes the need for tracking, others

may favor the use of copayments to discourage over-utilization. We therefore encourage States to consider the ease of tracking along with many other factors in devising their cost-sharing systems, but do not prescribe or recommend a specific cost-sharing design.

Comment: One commenter recommended that HCFA revise paragraph (d) of this section to require that State plans include a description of the disenrollment protections established pursuant to §457.570, in addition to the consequences for an enrollee who does not pay a charge. The commenter noted that §457.570 requires disenrollment protections; however, nothing in the regulation currently requires States to describe these processes in the State SCHIP plan.

Response: We agree with this comment. We intended to require States to include disenrollment protections in their State plans, as stated in the preamble to the proposed regulation. Therefore, we have revised §457.510(d) and §457.515(d) to include the State plan requirement that States provide a description of their disenrollment protections as required under §457.570.

Comment: Several commenters indicated that HCFA should require, rather than recommend, that States develop tracking mechanisms that do not rely on the beneficiary demonstrating to the State that he or she has met the cumulative cost-sharing

maximum. The commenters did not believe that the finding of the George Washington study (that States were not charging high enough cost-sharing to make it likely that families reached their cap) was good cause for a weaker standard. The commenters noted that States are currently experiencing very good budget climates that are likely to weaken at some point, perhaps causing States to raise their cost-sharing requirements. They also observed that expansion to higher income eligibility groups may cause States to increase cost sharing under SCHIP. Moreover, the commenters believed that all States could develop the capability to track enrollees' cumulative cost sharing if required, since some States do so currently. And the commenters urged that the requirement be imposed on States and contracting plans rather than individual providers, since such a responsibility could deter provider participation in SCHIP.

Response: As part of the study conducted by George Washington University, States were invited to a meeting to discuss tracking of cost sharing under SCHIP. During this discussion, HCFA noted that some States were capable of using sophisticated tracking mechanisms like swipe cards to track their cost sharing. These States typically have a large concentration of managed care entities with participating providers who already have in place hardware that aids in tracking cost sharing for the SCHIP population. However, States with providers located in

rural areas, and with providers who are not part of managed care networks, have indicated that it is administratively expensive to require States to put in place a sophisticated swipe card mechanism that would track cost sharing. Therefore, we have decided to continue to encourage States to use a tracking mechanism that does not rely on the enrollee, but will not require such a tracking mechanism due to implementation challenges and resource limitations in different States.

States must distribute, as part of the information furnished consistent with §§457.110 and 457.525 and general outreach activities, materials that inform the enrollee regarding his or her cost-sharing obligations, and assist the family in keeping track of the charges paid. At a minimum, States are required to include the schedule of cost-sharing charges, and the dollar amount of the enrollee's family's cumulative cost-sharing maximum. We also recommend that States educate the enrollee's family regarding tracking cost sharing against the cumulative cost-sharing cap.

Comment: Several commenters disagreed with our provision at §457.510(e) that "a methodology that primarily relies on a refund given by the State for overpayment (of cost sharing) by an enrollee is not an acceptable methodology." These commenters indicated that the use of a refund process can be the most cost effective and simple approach to ensuring that cost sharing does

not exceed limits, or that individuals exempt from cost sharing are not required to pay when it is not appropriate. The commenters believe States should be given the flexibility to develop their own process as long as the process guarantees that families will not have to pay cost-sharing charges for which they are not responsible. The commenters suggested that we consider that States are limited to a 10 percent cap on administrative costs, and that overly prescriptive measures added to administrative costs can take away from other important administrative functions, such as outreach and eligibility determinations. Several commenters also questioned how these provisions apply to a State that administers SCHIP through employer-sponsored health insurance plans.

Response: As stated in an earlier response, we recognize that there are situations in which the use of a refund methodology may be necessary. However, we believe States generally must be proactive and provide specific procedures for enrollees and their families to follow so that they are not overcharged cost sharing. A State methodology that merely reimburses or refunds enrollees for any cost sharing in excess of the cumulative cost-sharing maximum without including steps to help enrollees avoid overpayment will require the enrollees to outlay cash to obtain access to services that they should have been able to access without the burden of cost sharing. We view

such a refund policy to be contrary to the limits on cost sharing set forth in section 2103(e) of the Act.

Comment: One commenter suggested that we revise this section to require that, in describing the methodology used to ensure that total cost-sharing liability for an enrollee's family does not exceed the cumulative cost-sharing maximum, the State plan must describe how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost-sharing maximum. The commenter noted that the preamble stated that the description of the methodology must explain these areas. The commenter asked that this language be incorporated into the regulation.

Response: We agree with the general point that the commenter was making, that States should be required to disclose the principles used to calculate cumulative cost sharing maximums, but we believe such disclosure is equally important on an individual level as on a statewide level. Thus, we are adding paragraph (d) to 457.560, to require that the States provide the enrollee's family the precise dollar amount of the cumulative cost-sharing maximum at the time of enrollment and at the time of re-enrollment. However, we have not revised §457.510 because it already requires the State plan to describe the methodology for ensuring that cost sharing for a family does not exceed cumulative maximums, and this must include the information

described above. If the description submitted in a proposed State plan or amendment does not include a full explanation of how income is calculated for purposes of the cumulative cost sharing maximum and other relevant details, HCFA requests this information in reviewing the submission.

Comment: One commenter stated that, if a family must pay more than the customary rate for child care due to the special needs of the child, there should be a mechanism for that additional cost to be considered when determining financial status. Children with chronic conditions should be defined to include children with mental health and substance abuse conditions. Another commenter agreed with the finding of the George Washington study that children with chronic conditions or special needs often have expenses for related, non-covered services, which can create a tremendous financial burden for the family. The commenter recommended that the statute be changed to eliminate the cost-sharing provision for eligible children with chronic illness or other special needs. In this commenter's view, at a minimum, all related expenses should be counted toward the cumulative cost-sharing cap for these children. The commenter also agreed with the George Washington study's recommendation that States assign a case manager to children with chronic needs to assure that cost sharing does not exceed the cumulative cost-sharing maximum for these children.

Response: Title XXI does not include any special provision regarding cost sharing for children with special needs or chronic conditions and we appreciate the commenter's recognition that this issue is driven by the statute. States may consider the additional costs, including the costs associated with child care and case management, borne by families of children with special needs or chronic conditions when imposing cost sharing on this population, but HCFA does not have statutory authority to require that States take these costs into account. In addition, States may, at their option, exempt families of children with special needs or chronic conditions group from cost sharing, because the added costs of care can significantly reduce their disposable income. However, we have not specifically required States to exempt these children, and have therefore not included the commenter's recommendation in the regulation text.

Comment: Several commenters opposed our suggestion in the preamble that States count non-covered services towards the cumulative cost-sharing maximum.

Response: We do not require States to count the costs of non-covered services towards the cumulative cost-sharing maximum. However, we encourage States to consider the additional costs of uncovered services particularly for families with special needs children, when imposing cost sharing. States may pursue this policy option by counting non-covered services toward the

cumulative cost-sharing maximum or by implementing other State policies to limit the burden on such families.

4. Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements (§457.515).

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed. We proposed that the State plan describe the following elements regarding copayments, coinsurance, deductibles or similar charges: the service for which the charge may be imposed; the amount of the charge; the group or groups of enrollees to whom the charge applies; and the consequences for an enrollee who does not pay a charge. We proposed that the State plan describe the methodology used to ensure that total cost-sharing liability for an enrollee's family does not exceed the cumulative cost-sharing maximums. This description must explain how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost-sharing maximums.

Finally, we proposed, in accordance with the prudent layperson standard in the *Consumer Bill of Rights and Responsibilities*, that States must provide assurances that enrollees will not be held liable for costs for emergency services above and beyond the copayment amount that is specified in the State plan. Specifically, we proposed that the State plan

must include an assurance that enrollees will not be held liable for additional costs, beyond the copayment amounts specified in the State plan, that are associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network. In addition, we require that the State will not charge different copayment amounts for emergency services, based upon the location (in network or out of network) of the facility at which those services were provided. We indicated that we welcomed public comments on our proposed policy. In this final rule, we have added a provision to §457.515(d) that States must describe in the State plan the disenrollment protections adopted by the State pursuant to §457.570.

Comment: One commenter suggested that §§457.510(d) and 457.515(d), which require that the State plan describe the consequences for an enrollee who does not pay a charge, be revised to also require State plans to describe the consequences for a provider who does not receive a payment from an enrollee. The commenter indicated that providers should have information on the State's policy regarding unpaid copayments. The commenter questioned if providers may deny services to, or pursue collection from, enrollees who refuse to pay cost sharing. The commenter also asked if States will increase payments to providers when enrollees do not pay.

Response: Unlike under the Medicaid program, we do not have the statutory authority to prevent providers under separate child health programs from denying services to enrolles who do not pay their cost-sharing charges. Nor do we have clear authority to preclude providers or the State from billing the enrollee for unpaid cost-sharing charges. State plans should, consistent with fairness and equity, ensure that the provider or State gives the enrollee a reasonable opportunity to pay cost sharing before pursuing collection. Providers should refer the enrollee back to the State if he or she is demonstrating a pattern of non-payment, so that the State can review the financial situation of the enrollee. For example, the State should inquire whether the enrollee's income has dropped to a Medicaid eligibility level, or to a level of SCHIP qualification that does not require cost sharing or requires it at a lower level. We also suggest that States maintain open communication with providers regarding any financial losses for the provider resulting from non-payment of cost sharing. However, we note that the State's policy in this area is a matter of State discretion under this regulation.

Comment: One commenter urged HCFA to add a provision making clear that an enrollee may not be denied emergency services based on the inability to make a copayment, regardless of whether the provider is inside or outside of the enrollee's managed care network. The commenter also recommended that we include in the

preamble a discussion of the obligations of emergency services providers under the Emergency Medical Treatment and Active Labor Act (EMTALA).

Another commenter suggested that as a general rule for all SCHIP services, including emergency services, cost-sharing limits should apply only to services delivered through network participating providers. If there is to be an exception to this rule for emergency services, then cost-sharing limits should only apply to out-of-network emergency service providers that are not within a reasonable distance of network participating providers.

Response: While this is not an appropriate vehicle to discuss EMTALA responsibilities at length, when those responsibilities are triggered, a hospital cannot turn away a patient solely because of inability to pay. In addition, §457.410 requires States to provide coverage of emergency services; §457.495 requires States to ensure that SCHIP enrollees have access to covered services, including emergency services; and §457.515 specifies that enrollees cannot be held liable for cost sharing for emergency services provided outside of the managed care network.

If an enrollee goes outside of a managed care network to receive non-emergency services that are not authorized by the health plan, then the enrollee may be responsible for the full cost of the services provided. However, because of the nature of

emergency services and the importance of ensuring that enrollees receive such services without delay or impediment, such a situation is not reasonable. Thus, as we discuss further below, we have retained the regulation text at §457.515(f) providing that enrollee financial responsibility for emergency services must be equal whether the enrollee obtains the services from a network provider or out-of-network.

Comment: Several commenters supported the proposed requirement that beneficiary cost sharing for emergency services can not vary based on whether the provider is participating in a managed care network or not. One commenter specifically asserted that the use of differential copayments would be contrary to the spirit of the "prudent layperson" standard for emergency services. Another commenter recommended retaining or lowering the proposed maximum limit for copayments on emergency services, rather than raising the limit to levels parallel to those permitted in the Medicare+Choice programs, in light of the inability of many low-income families to access this amount at the time of an emergency.

Response: In keeping with the prudent layperson standard of assuring immediate access to emergency services, we have retained the prohibition against differential copays based upon location (in-network or out-of-network) under §457.515(f). These services are required to address an emergency and can be time sensitive,

and higher copayment levels for out of network providers might result in an unacceptable delay to determine whether the provider participates in the enrollee's managed care network. Furthermore, differential copayment levels might affect the ability of enrollees to access the closest and most accessible provider.

We have neither raised nor lowered the proposed permissible copayment levels for emergency services, because we believe the overall cost-sharing limitations are sufficient to protect enrollee families. We have not adopted the Medicare+Choice policy that would have permitted a $5.00 copayment for emergency medical services. The cost sharing provisions at §457.555 will apply to emergency medical services.

Comment: We received a comment on our statement in the preamble that we considered adopting the Medicare+Choice policy regarding emergency services obtained outside of the provider network. The commenter noted that limitations on emergency room cost sharing at Medicare+Choice levels, whether in network or out of network, could be administratively burdensome to group health plans and participating providers, and might dissuade such entities and practitioners from contracting with SCHIP.

Response: As noted above, we have not adopted the Medicare+Choice policy described in the preamble to the proposed rule. We do note, however, that premium assistance programs are

subject to the same cost-sharing requirements and protections as other types of SCHIP programs. Such protections are required by statute and recognize the unique financial constraints of the SCHIP population. In situations where employer plans charge more than is permissible under these rules, the State will need to develop a mechanism to prevent enrollees from paying excess charges.

5. Cost sharing for well-baby and well-child care (§457.520).

Under section 2103(e)(2) of the Act, the State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby and well-child care services in either the managed care or the fee-for-service delivery setting. At proposed §457.520, we set forth services that constitute well-baby and well-child care for purposes of this cost-sharing prohibition. We proposed to define these well-baby and well-child services consistent with the definition of well-baby and well-child care used by the American Academy of Pediatrics (AAP) and incorporated in the Federal Employees Health Benefits Program (FEHBP) Blue Cross and Blue Shield benchmark plan.

We also proposed to apply the prohibition on cost sharing to services that fit the definition of routine preventive dental services used by the American Academy of Pediatric Dentistry (AAPD) when a State opts to cover these services under its program.

We proposed at §457.520 that the following services are considered well-baby and well-child care services for the purposes of the prohibition of cost sharing under section 2103(e)(2):

- All healthy newborn inpatient physician visits, including routine screening (whether provided on an inpatient or on an outpatient basis).
- Routine physical examinations.
- Laboratory tests relating to their visits.
- Immunizations, and related office visits as recommended in the AAP's *"Guidelines for Health Supervision III"* (June 1997), and described in *"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"* (Green M., (ed.). 1994).
- When covered under the State plan (at the State's option) routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the AAPD's current *Reference Manual* (Pediatric Dentistry, Special Issue, 1997-1998, vol 19:7, page 71-2).

Comment: One commenter noted that the language of this section is ambiguous in stating that the "State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby/well child care services as defined by

the State." HCFA should clarify that no preventive service as defined by the Guidelines for Health Supervision III (including the appended Recommendations for Preventive Pediatric Health Care) and Bright Futures is subject to cost sharing, as was intended by the underlying statute.

Response: We agree with the commenter and have revised §457.520(a) to be clearer that a State may not impose cost sharing on services that would ordinarily be considered well-baby and well-child care. As described in subpart D, Benefits, States may define well-baby and well-child services for coverage purposes. While this may provide States flexibility in determining the appropriate scope of benefits, such flexibility is not appropriate with respect to cost sharing which might deter appropriate utilization of covered services. Thus, we are specifying in §457.520(a) that cost sharing may not be imposed on any covered services that are also within the scope of AAP well-baby and well-child care recommendations.

Comment: One commenter noted that there are differences between the discussion of this provision in the preamble (64 FR 60913) and in the regulations text (64 FR 60955). The commenter believed the provision as set forth in the regulations text is more clear.

Response: In this final rule, we are adopting the provisions regarding well-baby and well-child care as set forth

in the regulations text at §457.520, except that we have amended these provisions to clarify the scope of services to which the prohibition on cost sharing applies.

Comment: A number of commenters expressed concern that adolescent health care services are not specifically listed as well-baby and well-child care services exempt from cost sharing. Although the preamble notes that well-child care includes health care for adolescents, the commenters urged HCFA to make specific mention of this fact in the regulation. One commenter recommended that HCFA define adolescent health care services using the schedules from the American Medical Association's "Guidelines for Adolescent Preventive Services," and the American College of Obstetricians and Gynecologists, "Primary and Preventive Health Care for Female Adolescents" as well as those of the American Academy of Pediatrics. Another commenter noted that there is no reason why a physical exam for a toddler should be exempt from cost-sharing requirements while an exam and related services for an adolescent are not.

Response: It is not necessary to add the term adolescent to the regulation because the term "child" as defined by the statute and regulation refers to enrollees under the age of 19 the cost-sharing rules set forth in this regulation apply to all children under age 19. Therefore, States cannot impose cost sharing on any well-child care services provided to an adolescent under the

age of 19. In addition, the standard recommended by the AAP for routine physical exams specifically includes treatment of adolescents.

Comment: One commenter disagreed with the use of a specific immunization schedule because it may be difficult for States using employer-sponsored insurance to implement this requirement. The commenter recommended that we revise the regulation to state "Immunizations and related office visits as medically necessary.?

Response: We are not accepting the commenter's suggestion because immunizations recommended by the Advisory Commission on Immunization Practices (ACIP) are generally accepted as being medically necessary. The State is responsible for assuring that an enrollee does not pay cost sharing for any immunizations recommended by ACIP.

Comment: One commenter recommended that the immunization schedule include updates.

Response: As proposed, §457.520(b)(4) prohibits cost sharing for immunizations and related office visits as recommended by ACIP. We are retaining this language in the final regulation at §457.520(b)(4) which also indicates that updates to these guidelines must be reflected in States cost-sharing policies.

Comment: One commenter urged that HCFA remove the term "routine physical examinations" from the list of well-baby and

well-child care services. The inclusion of this term is confusing in this commenter's view because almost every office visit for children entails a "physical examination" as part of the evaluation and management component of the office visit. As an alternative, the commenter recommended using the language for well-baby and well-child care services as listed in §457.10. Other commenters recommended that routine exams be specifically tied to professionally established periodicity schedules.

Response: We agree that our intent may have been unclear. We have revised §457.520(b)(2) to provide that the well-baby and well-child routine physical exams, as recommended by the AAP's "Guidelines for Health Supervision III", and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents", (which would include updates to either set of guidelines) may not be subject to cost sharing.

Comment: Several commenters stated that lab tests should not be exempt from cost sharing, especially given that lab tests are expensive and not always preventive. Since lab services are provided by a separate entity, outside of the office of the physician providing the well-baby and well-child care service, States should be given flexibility in determining whether to exempt lab services from cost sharing, particularly in managed care settings. One commenter requested that HCFA clarify the intention of the provisions excluding lab services from cost

sharing. The commenter questioned if the exemption is limited to laboratory tests that are associated with the well-baby and well-child visit.

Response: We have revised the regulation text at §457.520(b)(3) to indicate that States are required to exempt from cost sharing only those lab tests associated with the well-baby/well-child routine physical exams described in §457.520(b)(2). We believe the exemption from cost sharing for these lab tests is consistent with the statutory intent that there is no cost sharing imposed on enrollees for well-baby and well-child care services. All other lab tests that are not routine and not part of a well-baby or well-child visit may be subject to cost-sharing charges consistent with the other cost-sharing provisions of this subpart.

Comment: Several commenters indicated their view that States should have the flexibility to determine how best to improve access to dental services. In their view, the prohibition of cost-sharing for dental services may discourage States from offering dental services under SCHIP because it is an optional benefit. One commenter recommended prohibiting States from imposing copayments, deductibles, coinsurance or other cost sharing for all covered dental services. This commenter indicated that the Medicaid program has clearly demonstrated that imposing costly, difficult, and risk shifting management

procedures on providers severely limits participation in such programs and therefore severely restricts access to essential oral health care for this high risk, high need population. The commenter stated that, for example, if a child arrives in a dental office without the appropriate cost-sharing funds, the practitioner must either defer the needed service, enter into costly billing procedures, or waive the money due and such waivers previously have, on some occasions, been interpreted as insurance fraud. The commenter indicated that our policy may discourage practitioners from participating in the SCHIP program and result in problems of access to care for the children with the greatest need.

Response: The majority of separate child health programs offer dental benefits and do not impose cost sharing on preventive dental services. If States were to impose cost sharing on preventive benefits, due to their limited incomes, enrollees would only access services when needed and when services are most expensive. Almost all States have elected to provide at least some dental coverage in their State plans without cost sharing for preventive services. The cost-sharing exemption policy has not caused States to discontinue coverage of dental services thus far. In addition, we note that the cost-sharing exemption on well-baby and well-child care services is based upon section 2103(e)(2)of the Act, which provides that the

State plan may not impose cost sharing on benefits for these preventive services. We have interpreted this statutory provision to support the cost-sharing exemption for routine preventive and diagnostic dental services.

6. Public schedule (§457.525).

Section 2103(e)(1)(A) of the Act requires that the State provide a public schedule of all cost-sharing charges. We proposed that the public schedule contain at least the current SCHIP cost-sharing charges, the beneficiary groups upon whom cost sharing will be imposed (for example, cost sharing imposed only on children in families with income above 150 percent of the FPL), the cumulative cost-sharing maximums, and the consequences for an enrollee who fails to pay a cost-sharing charge. We also proposed that the State must make the public schedule available to enrollees at the time of enrollment and when the State revises the cost-sharing charges and/or cumulative cost-sharing maximum, applicants at the time of application, SCHIP participating providers and the general public. To ensure that providers impose appropriate cost-sharing charges at the time services are rendered, we proposed that the public schedule must be made available to all SCHIP participating providers. In this final rule, we have added §457.525(a)(4) which indicates that the State must include in the public schedule, the mechanisms for making payments for required charges. We also added to §457.525(a)(5)

that the public schedule describe the disenrollment protections pursuant to §457.570.

Comment: Several commenters recommended that States have the option to provide information in the public schedule that defines cumulative cost sharing as a percentage of income. The commenters requested that we clarify that States can defer responsibility for distributing the public schedule to all SCHIP providers to the managed care entities as part of their contractual obligations.

Response: States may define the cumulative cost-sharing maximum as a percentage of income in the public schedule and request that managed care entities distribute the public schedule to all SCHIP providers (although the State retains the responsibility that the entities involved make the schedule available to providers). However, we have modified the regulation at §457.110(b)(2) to indicate that States must calculate the precise amount of the cumulative cost-sharing maximum (the dollar amount instead of a percentage of income) that applies to the individual enrollee's family at the time of enrollment (as well as at the time of re-enrollment) to maximize the usefulness of information provided to the family and to ensure uniform calculation of the amount, maximize the usefulness of the information, and make tracking easier.

Comment: One commenter urged HCFA to include language in

the preamble that “applicants” and “enrollees” include adolescents (independent from other children in their family) and that information should be directed to them about any schedule of costs. The commenters noted that adolescents often seek care on their own, not only for services that they need on a confidential basis, but for other services as well. Unless they are aware of the charges they may encounter, and the services that do not require a copayment, they may be deterred from seeking care, in this commenter’s view.

Response: Section 457.525(b) specifically requires States to provide a public schedule, which includes a description of the plan’s current cost-sharing charges, to SCHIP enrollees at the time of application, enrollment, and when cost-sharing charges are revised. We have added a provision at §457.525(b)(1) requiring that States provide SCHIP enrollees the public schedule at reenrollment after a redetermination of eligibility as well. This section also requires that cost-sharing charges be disclosed to SCHIP applicants at the time of application. SCHIP enrollees, by definition, are children under age 19. In most cases, this information will be given to family members due to the age of the child. However, we encourage States to provide information about cost sharing directly to adolescent applicants and enrolles when appropriate. We also encourage States to consider the range of applicants, enrollees and family members who might benefit from

the provision of this information, including adolescents, and we encourage States to describe the plan's current cost-sharing charges in language that is easily understood and tailored to the needs of target populations, consistent with section 457.110.

Comment: One commenter suggested that the requirement to provide the public schedule to applicants may be overwhelming to both the program and the applicants. Enrollees are most interested in the information relating to the family's individual obligations.

Response: Section 2103(e)(1)(A) of the Act provides sufficient authority to require States to make a public schedule available, and to provide all interested parties with notice of cost-sharing obligation for the program. In addition, applicants should be given a chance to review the cost sharing structure prior to enrollment, so that the applicant will understand the potential costs of SCHIP and can make a reasoned choice as a health care consumer. This policy also aids in future tracking of the family's cost-sharing obligation.

Comment: One commenter recommended that HCFA require that the public schedule contain information about an enrollee's rights with respect to cost sharing, including the right to receive notice and make past due payments, as well as other protections established by the State in compliance with §457.570.

Response: Section 457.525(a)(5) of this final rule requires

that the public schedule include a description of the consequences for an enrollee who does not pay a cost-sharing charge. We are also revising this section to require States to discuss, as part of this description, the disenrollment protections it has established pursuant to §457.570. Section 457.570 requires States to provide enrollees with an opportunity to pay past due cost sharing, as well as an opportunity to request a reassessment of their income, prior to disenrollment.

Comment: One commenter recommended that we require States to include detailed information about the cost-sharing schedule at each annual renewal and in the SCHIP application packet/pamphlet. Applications should also include information to notify participants of services that are subject to cost sharing.

Response: We have revised §457.525(b)(1) to require that States also provide the public schedule at the time of a re-enrollment after a redetermination of eligibility. In addition, we note that §457.525(a)(1) requires that the public schedule of cost-sharing requirements include information on current cost-sharing charges and the cumulative cost-sharing maximums. This information should specify the services or general category of services for which cost sharing is imposed and services that are exempt from cost sharing.

7. General cost-sharing protection for lower income children (§457.530).

At §457.530, we proposed to implement section 2103(e)(1)(B) of the Act, which specifies that the State plan may only vary premiums, deductibles, coinsurance, and other cost-sharing charges based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income. We noted that this statutory provision and the implementing regulations apply to all cost sharing imposed on children regardless of family income.

Comment: One commenter requested that when considering the requirement that States not vary cost sharing based on the family income of the targeted low-income children in a manner that favors children from families with higher income over children from families with lower income, HCFA should consider the issue of disposable income. The commenter recommended that we should consider only the income the family receives above 100 percent of the FPL (disposable income). When applying a flat percentage assessment, the assessment will consume more of the lower-income family's disposable income than the disposable income of a higher-income family. The commenter cited the following example: a straight 3 percent assessment would consume 9 percent of the disposable income for a family at 150 percent of poverty but only 6.5 percent of the income for a family at 185 percent of poverty.

Response: We recognize that health care costs may consume a

larger proportion of a lower income family's disposable income. Accordingly, at §457.560(d), we provide for a lower cumulative cost-sharing maximum (2.5 percent) for cost sharing imposed on children in families at or below 150 percent of the FPL in part because of the higher proportionate consumption of disposable income at lower poverty levels. Also, in accordance with §457.540(b), and section 2103(a)(1)(B) of the Act, copayments, coinsurance, deductibles and similar charges imposed on children whose family income is at or below 100 percent of the FPL may not be more than what is permitted under the Medicaid rules at §447.52 of this part and the charges may not be greater for children in lower income families than for children in higher income families.

8. Cost-sharing protection to ensure enrollment of American Indians/Alaska Natives (§457.535).

Section 2102(b)(3)(D) of the Act requires the State plan to include a description of the procedures used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act). To ensure the provision of health care to children from AI/AN families, we proposed that States must exclude AI/AN children from the imposition of premiums, deductibles, coinsurance, copayments or any other cost-sharing charges. For the purposes of this

section, we proposed to use the definition of Indians referred to in section 2102(b)(3)(D) of the Act, which defines Alaska Natives and American Indians as Indians defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). We also specified in the regulation that the State must only grant this exception to AI/AN members of Federally recognized tribes (as determined by the Bureau of Indian Affairs).

Comment: Several commenters requested that HCFA reconsider the AI/AN exemption. Many commenters noted that it is administratively burdensome (especially in States with small AI/AN populations) and expensive in light of the fact that a number of States have already negotiated contracts with health care entities that assume cost sharing for this population and application of the 10 percent limit on administrative expenditures. Many commenters recommended that we focus on technical assistance instead to assure that States are consulting with tribes. Some commenters were concerned that having no cost sharing for this group, but having it for other children in the program would single out AI/AN children in health care provider offices and facilities. Also, commenters believed our policy contradicts the statutory intent to prevent discrimination against children with lower family incomes. In their view, the elimination of cost sharing in these situations creates a different standard for a specific population group and may imply

to both providers and families SCHIP enrollees that AI/AN children's parents cannot be relied upon to pay anything toward the costs of their health care. One commenter observed that if HCFA's reason for exemption is because AI/AN children are typically unable to pay cost sharing, then the exemption should apply to special needs children as well.

Response: Section 2102(b)(3)(D) of the Act requires that a State ensure the provision of child health assistance to targeted low-income children in the State who are Indians. In accordance with this statutory provision and to enhance access to child health assistance, we have specified that States may not impose cost sharing on this population. This exemption is consistent with section 2103(e)(1)(B) of the Act because this statutory provision prohibits States from imposing cost sharing based on the family income of targeted low-income children in a manner that favors children from families with higher income over children from families with lower income. The exemption from cost sharing for AI/AN children is not a variation of the cost sharing based on the family's income and is not a violation of section 2103(e)(1)(B). The cost-sharing exemption for AI/AN children is based upon the statutory requirement at section 2102(b)(3)(D), which requires particular attention to this population.

This cost-sharing exemption also reflects the unique Federal

trust with and responsibility toward AI/ANs. The statute specifically singles out children who are AI/ANs and requires that States ensure that such children have access to care under SCHIP. The statute confirms that AI/AN children are a particularly vulnerable population, and that a requirement to pay cost sharing will act as a barrier to access to care for this population. Therefore, in order to operate a SCHIP program in compliance with section 2103(b)(3)(D), the only way to ensure access to AI/AN children is to exempt them from the cost-sharing requirements. In addition, absent this exemption for AI/AN children, these children may pursue services from the Indian Health Service (IHS) (where cost sharing is not required) without pursuing coverage under SCHIP or Medicaid. We disagree with the commenter's assertion that a similar exemption should be granted for children with special needs, there is no parallel statutory provision that requires States ensure access to this population. While the unique medical needs of this population are not insignificant, the AI/AN exemption is based on the Federal tribal relationship and responsibility for protection of this specific group. However, we do not believe there is sufficient rationale or authority for including special needs children under this exemption.

We further recognize that it may be administratively burdensome for some States to exempt this population if States

are required to verify the status of the enrollee as Indians. However, States may rely on the beneficiary to self-identify their membership in a Federally-recognized tribe and self-identification would substantially reduce the administrative burden and associated costs to the State. Also, this exemption will not single out AI/AN children at providers' offices and facilities if the State requires the enrollee to self-identify at the time of enrollment and the State provides inconspicuous identification for these children so that providers know not to charge them cost sharing at the time the enrollee receives services.

Comment: One commenter asked HCFA to clarify that cost-sharing charges are not imposed by Tribal clinics or community health centers.

Response: Under §457.535, the AI/AN population is exempt from cost sharing. IHS facilities and tribal facilities operating with funding under P.L. 93-638 ("tribal 638 facilities") do not charge cost sharing to the AI/AN population.

Comment: Several commenters recommended that the States' costs incurred due to the AI/AN exemption should be reimbursed with 100 percent Federal funds.

Response: A State will be able to claim match for increased costs resulting from the AI/AN exemption at the State's enhanced matching rate. However, we do not have authority under title XXI

to provide 100 percent FMAP for these costs and would therefore need a legislative change to do so.

Comment: Several commenters recommended that AI/AN enrollees be permitted to self-certify their AI/AN status if HCFA does not concur with the commenter's request to remove the AI/AN cost-sharing exemption.

Response: We agree and take note that we have revised the policy set forth in the preamble to the proposed rule. States may allow self-identification for the purposes of the AI/AN cost-sharing exemption. Self-identification is consistent with our policies that encourage States to simplify the application and enrollment processes.

Comment: One commenter suggested that we apply the AI/AN cost-sharing exemption to all Indians based on the definition referred to in section 2102(b)(3)(D). The commenter requested that we remove the provision in the proposed regulation at §457.535 that would narrow this definition to "AI/AN members of a Federally recognized tribe." The commenter stated that this definition of AI/AN children is more restrictive than that in the Indian Health Care Improvement Act, has no basis in title XXI and it is also inconsistent with the definition of Indian set forth in the consultation provisions at §457.125(a), which expressly request that States consult with "Federal recognized tribes and other Indian tribes and organizations in the State..."

The commenter indicated the view that there is little point in consulting with non-Federally recognized tribes about enrollment in SCHIP if the children of those tribes are not excluded from the premiums and cost sharing.

Response: Because the Federal/tribal relationship is focused only on AI/ANs who are members of Federally recognized tribes, this final rule only requires States to exempt from cost sharing AI/ANs who are members of Federally recognized tribes. With regard to the consultation requirements at proposed §457.125(a), we note that, although the cost-sharing exemption is required only for AI/ANs who are members of a Federally recognized tribe, individuals from other tribes may be eligible for child health assistance under SCHIP. There are numerous issues other than cost sharing that are involved in designing and operating a program, and we believe that States should be open to consultation with all interested parties, including non-federally recognized tribes. As such, we have removed the consultation requirement from §457.125 and encourage the participation of these groups in the public involvement process established by the State in accordance with the new §457.120(c). Finally, we have modified the definition of American Indian/Alaska Native at §457.10 to be consistent with the Indian Health Care Improvement Act, yet also comport more closely with the definition used in the Indian Self Determination Act (ISDEAA).

Comment: One commenter suggested that HCFA allow time for States to comply with this new requirement and not delay approval of State plans or plan amendments for the time it will take to change State law to implement this change.

Response: In a letter dated October 6, 1999, HCFA informed SCHIP State health officials that we interpret the SCHIP statute to preclude cost sharing on AI/AN children. Since October 1999, we have required States submitting State plan amendments to alter cost sharing to comply with the exemption in order to gain approval for these amendments. States that have not submitted such amendments have been given ample notice of this policy. We will expect all States to comply with the requirements of §457.565(b), which implements the exemption of AI/AN targeted low-income children from cost sharing and comply immediately with this requirement upon the effective date of this regulation.

Comment: One commenter suggested that States with small AI/AN Indian populations be waived from the cost sharing exemption so they can continue their programs as implemented.

Response: We realize there is some concern about the administrative difficulties related to exempting AI/AN children from cost sharing in States with small AI/AN populations. However, as noted above, we will permit AI/AN applicants to self-identify at the time of enrollment for the purposes of the cost-sharing exemption. This policy minimizes the administrative

burden on States.

Comment: Two commenters asked HCFA to clarify that, in States with SCHIP or Medicaid expansions involving AI/AN adults or entire families, the cost-sharing exemption be applied to AI/AN adults as well.

Response: In States with separate child health programs or Medicaid expansions that provide coverage to AI/AN adults or entire AI/AN families, the cost-sharing exemption only applies to children. If a State has imposed a premium on the family, the State must reduce the premium proportionately so that it applies to adults only. They also must not deny children access to coverage if the adults in the family cannot make premium payments. We are not restricting cost sharing for AI/AN adults because section 2102(b)(3)(D) directly refers to children only.

9. Cost-sharing charges for children in families at or below 150 percent of the Federal poverty line (FPL) (§457.540).

Section 2103(e)(3) of the Act sets forth the limitations on premiums and other cost-sharing charges for children in families with incomes at or below 150 percent of the FPL. Pursuant to section 2103(e)(3)(A)(I) of the Act, we proposed that in the case of a targeted low-income child whose family income is at or below 150 percent of the FPL, the State plan may not impose any enrollment fee, premium, or similar charge that exceeds the charges permitted under the Medicaid regulations at §447.52,

which implement section 1916(b)(1) the Act. Section 447.52 specifies the maximum monthly charges in the form of enrollment fees, premiums, and similar charges, for Medicaid eligible families.

Section 2103(e)(3)(A)(ii) provides that copayments, coinsurance or similar charges imposed on children in families with income at or below 150 percent of the FPL must be nominal, as determined consistent with regulations referred to in section 1916(a)(3) of the Act, with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The Medicaid regulations that set forth these nominal amounts are found at §447.54. For children whose family income is at or below 100 percent of the FPL, we proposed that any copayments, coinsurance, deductibles or similar charges be equal to or less than the amounts permitted under the Medicaid regulations at §447.54. For children whose family income is at 101 percent to 150 percent of the FPL, we proposed adjusted nominal amounts for copayments, coinsurance, and deductibles to reflect the SCHIP enrollees ability to pay somewhat higher cost sharing. We proposed that the frequency of cost sharing meet the requirements set forth in proposed §457.550.

We also proposed that the cost sharing imposed on children in families with incomes at or below 150 percent of the FPL be limited to a cumulative maximum consistent with proposed

§457.560. Specifically, we proposed that total cost sharing imposed on children in this population be limited to 2.5 percent of a family's income for a year (or 12 month eligibility period).

Comment: One commenter questioned if the cost-sharing limits at §§457.540, 457.545, 457.550, 457.555 and 457.560 apply to out-of-network cost-sharing charges. The commenter recommended that the limits only apply to services delivered through the network participating providers. If not, the commenter argued that States cannot effectively use managed care to control costs and will be unable to develop effective partnerships with employer-sponsored health insurance programs to provide SCHIP services.

Response: If an enrollee receives services outside of the network that were not approved or authorized by the managed care entity (MCE) to be received outside of the network, then the services are considered non-covered services and the enrollee may be responsible for related cost-sharing charges imposed (other than in the case of emergency services provided under §457.555(d)) irrespective of the limits established under the above referenced sections. If, however, the services are authorized by the MCE and provided by an out-of-network provider, the cost-sharing limits of this subpart apply. A State must ensure enrollees access to services covered under the State plan, but a State has discretion over whether to use a fee-for-service

or a managed care arrangement.

Comment: A couple of commenters observed that the premium limits as set forth in the Medicaid regulations at §447.52 are unreasonably low, since these cost-sharing provisions and limits have not been updated since the 1970s. These commenters proposed that we use a percentage (of payment) to set these amounts instead of a flat dollar amount.

Response: Section 2103(e)(3)(A)(I) provides that States may not impose enrollment fees, premiums or similar charges that exceed the maximum monthly charges permitted, consistent with the standards established to carry out section 1916(b)(1) of the Act. Permitting States to charge higher premiums on families with incomes at this level of poverty would be inconsistent with the statute.

Comment: One commenter suggested that the rule and preamble explicitly address the cost sharing treatment of children in families below the Federal Poverty Level. They noted that, in States that have retained the resource test for children in Medicaid, significant numbers of children below poverty will be enrolled in separate child health programs due to excess assets. This commenter recommended that §457.540 be revised to reflect the fact that some adolescents under 100 percent of the FPL may be receiving SCHIP services until they are fully phased into regular Medicaid and that protections must apply to these

children as well.

Response: Section 457.540(b) of the proposed regulation addresses the need for lower cost-sharing limits for cost sharing imposed on all children below 100 percent of the FPL. This section limits cost sharing to the uninflated Medicaid cost-sharing limits permitted under §447.54 of this chapter. Section 2103(e)(3)(A)(I) limits premiums, enrollment fees, or similar charges to the maximums permitted in accordance with section 1916(b)(1) of the Act. In addition, because the definition of "child" includes adolescents under the age of 19, there is no need to revise this section. We have retained this proposed provision in the final regulation. However, it should be noted that we have added paragraphs (d) and (e) to §457.540. These requirements were originally part of §457.550, which has been removed to improve the format of the regulation.

Comment: One commenter disagreed with the separate grouping, relative to cost sharing, for SCHIP enrollees under 100 percent of the FPL and the application of the Medicaid cost-sharing limits to this population. The commenter noted that the proposal is beyond the statute (the statute only refers to two tiers - above 150 percent of the FPL and at or below 150 percent of the FPL) and that the monetary difference between the SCHIP schedule applicable to 101 percent to 150 percent of the FPL and the Medicaid cost-sharing schedule is minimal. The commenter

noted that the cost to States to create a program for this new income level is very significant. The commenter argued that the Medicaid cost-sharing requirements proposed for SCHIP enrollees under 100 percent FPL were developed two decades ago and have no connection to current health care costs or program changes. According to this commenter, creating this new tier of eligible SCHIP enrollees does not seem to comport with the flexibility provided States in the Congressional debate on SCHIP, or written in title XXI.

Response: Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose "a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with the regulations referred to in section 1916(a)(3) of the Act), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable." The Secretary has the discretion to determine the increases to the Medicaid cost-sharing limitations that are reasonable and under this authority the Secretary has determined that it is not reasonable for States to impose cost sharing above the Medicaid limitations contained in §447.54 for children with family incomes that are below the Federal poverty line. As noted in the comment above, children at this income level who are eligible for separate child health programs typically reside in States that have retained the resource test for children in

Medicaid, and may be well below 100 percent of the FPL. In this case, even small increments in cost sharing may impact the ability to access services.

10. Cost sharing for children in families above 150 percent of the FPL (§457.545).

Section 2103(e)(3)(B) mandates that the total annual aggregate cost sharing with respect to all targeted low-income children in a family with income above 150 percent of the FPL not exceed 5 percent of the family's income for the year involved. The proposed regulation provided that the plan may not impose total premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges in excess of 5 percent of a family's income for a year (or 12 month eligibility period). We have deleted this section because it repeats the requirements already stated in §457.560(c). Please see the comments and responses at §457.560(c) for further discussion.

11. Restriction on the frequency of cost-sharing charges on targeted low-income children in families at or below 150 percent of the FPL (§457.550).

Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, "with such appropriate adjustments for inflation or

other reasons as the Secretary determines to be reasonable". We proposed to adopt the Medicaid rule at §447.53(c) that does not permit the plan to impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service. We also proposed that a State may not impose more than one cost-sharing charge for multiple services provided during a single office visit.

We also proposed to adopt the Medicaid rules at §447.55 regarding standard copayments. Specifically, we proposed to provide that States can establish a standard copayment amount for low-income children from families with incomes from 101-150 percent FPL for any service. We proposed to expand upon the Medicaid rules and allow States to provide a standard copayment amount for any visit. Similar to the provisions at §447.55 that allow a standard copayment to be based upon the average or typical payment of the service, our proposed provision would allow a State to impose a standard copayment per visit for non-institutional services based upon the average cost of a visit up to the copayment limits specified at proposed §457.555(a), on these families.

Comment: A few commenters asked if States can still charge an enrollment fee. HCFA should clarify that States can charge both an enrollment fee for SCHIP and copayments for services, provided aggregate and individual dollar limits on cost sharing

are observed.

Response: States can charge an enrollment fee for families at or below 150 percent FPL as long as the enrollment fee does not exceed the maximums specified in §457.540(a) for children in families at or below 150 percent of the FPL and does not exceed the cumulative cost-sharing maximum in accordance with §457.560(d) (2.5 percent of a family's income for a year or length of the child's eligibility period). For enrollment fees imposed on children in families with income above 150 percent of the FPL, enrollment fees and other cost sharing are limited to the cumulative cost-sharing maximum specified in §457.560(c) (5 percent of the enrollee's family income for a year or the length of the child's period of eligibility). The restriction on imposition of one type of cost sharing in this section applies only to copayments, deductibles, and coinsurance or similar charges.

Comment: One commenter strongly supported the provision of the proposed rule that prohibits imposition of more than one copayment for multiple services provided during a single office visit. The commenter noted that this is a key issue for adolescents and that adolescents seek a variety of health care services on their own and seek to do so on a confidential basis (for example, diagnosis and treatment for a sexually transmitted disease). The commenter recommended that the preamble (or

regulation) clarify whether there can be only one copayment required for a single office visit (for example, a $5.00 copayment for the visit) and whether the copayment must cover any associated lab tests, diagnostic procedures, and prescription drugs, or whether any additional copayments can be required. The commenter urged that HCFA make clear that only one copayment per visit may be required for all services associated with the single visit.

One commenter opposed the prohibition on imposing more than one cost-sharing charge for multiple services provided during a single office visit. In the commenter's view, cost sharing should relate to the provision of services rather than a visit. The commenter noted that CPT IV codes for physicians do not bundle multiple physicians or multiple services into a single visit. In this commenter's view, the proposed rule is also more restrictive than the current Medicaid provisions, which tie cost sharing to services, not to visits. The commenter argued that this added restraint on cost sharing is unnecessary because SCHIP enrollees are already protected from excessive charges by the overall cost-sharing caps and the limits on copayments.

Response: Section 457.550(b) (now §457.540(e)) specifies that States cannot impose more than one copayment for multiple services furnished during one office visit. Thus, the copayment must cover any associated lab tests and diagnostic procedures.

Only one copayment per visit may be required for all services delivered during the single visit. Lab tests performed at another site or prescription drugs obtained at a pharmacy may be subject to additional copayments. While the commenter notes that this is more restrictive than Medicaid, under Medicaid a provider cannot deny services to an enrollee if he or she cannot pay the associated copayment. SCHIP providers can deny services to enrollees under these circumstances. The per visit cost-sharing limit is intended to prevent access problems for SCHIP enrollees.

Comment: Several commenters requested that §457.550(b) not apply to dental services or vision services because they are benefits that are defined by each individual service. In these commenters' view, limiting the frequency of cost sharing jeopardizes the State's ability to contract with many participating dental providers and limits the provision of needed dental services for SCHIP enrollees.

Response: The majority of State child health programs offer coverage for dental services and we believe this provision will not adversely affect State coverage of these services. In addition, provider participation is more likely to be influenced by States' payment rates than by cost sharing from enrollees. Once again, we believe it is important that the cost sharing on enrollees at or below 150 percent of the FPL be nominal in order to encourage enrollees to access vision and dental services

before more expensive treatment is required.

Comment: One commenter indicated that §447.550(b) should state that "any copayment that the State imposes under a fee for service system may not exceed $5.00 per visit, regardless of the number of services furnished during one visit." Because the commenter assumes that the provider will seek the highest allowable copayment, for clarity, the rule should simply state that $5.00 is the maximum allowable per copayment visit. Section 457.550(b) is redesignated as §457.540(e).

Response: We have modified the regulation to clarify that the provider can only collect up to the maximum amount allowed by the State based on the total cost of services delivered during the office visit. The provider cannot charge copayments in excess of what the State permits under the State plan.

Comment: One commenter pointed out an error in paragraph (c) of §457.550, which refers to the maximum copayment amounts specified in paragraphs (b) and (c) of this section. The reference should be to §457.555(b) and (c).

Response: We agree with the commenter and have made these corrections to the final regulation text (§457.550(c) has been redesignated as §457.555(e)). In addition, we have revised the reference to include subsection (a) as well.

12. Maximum allowable cost-sharing charges on targeted low-income children between 101 and 150 percent of the FPL

(§457.555).

Section 2103(e)(3)(A)(ii) of the Act specifies that for children in families with incomes below 150 percent of the FPL, the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, "with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable". We proposed provisions regarding maximum allowable cost-sharing charges on targeted low-income children at 101 to 150 percent of the FPL that mirror the provisions of §§447.53 and 447.54 but are adjusted to permit higher amounts.

Specifically, for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent we proposed the following service payment and copayment maximum amounts for charges imposed under a fee-for-service system:

Total cost of services provided during a visit	Maximum amount chargeable to enrollee
$15.00 or less	$1.00
$15.01 to $40	2.00
$40.01 to $80	3.00
$80.01 or more	5.00

We proposed to set a maximum per visit copayment amount of $5.00 for enrollees enrolled in managed care organizations. In addition, we proposed to set a maximum on deductibles of $3.00 per month per family for each period of SCHIP eligibility. We noted that, if a State imposes a deductible for a time period other than a month, the maximum deductible for that time period is the product of the number of months in the time period by $3.00. For example, the maximum deductible that a State may impose on a family for a three-month period is $9.00.

We also proposed, for the purpose of maximums on copayments and coinsurance, that the maximum copayment or coinsurance rate relates to the payment made to the provider, regardless of whether the payment source is the State or an entity under contract with the State.

With regard to institutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL, we proposed to use the standards set forth in the Medicaid regulations at §447.54(c). Accordingly, we proposed

to require that for targeted low-income children whose family income is at or below 150 percent of the FPL, the State plan must provide that the maximum deductible, coinsurance or copayment charge for each institutional admission does not exceed 50 percent of the payment made for the first day of care in the institution.

We proposed to allow States to impose a charge for non-emergency use of the emergency room up to twice the nominal charge for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL. In §457.555(d), we further proposed that States must assure that enrollees will not be held liable for additional costs, beyond the specified copayment amount, associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network.

We realized that the regulation text as proposed regarding the limit on cost sharing related to emergency services was not clear. Therefore, we have added to §457.555(a) that the cost-sharing maximums provided in this section apply to non-institutional services provided to treat an emergency medical condition as well. We also clarified in paragraph (c) that any cost sharing the State imposes for services provided by an institution to treat an emergency medical condition may not exceed $5.00. We also removed proposed paragraph (d), because

this requirement is already included in §457.515(f)

Comment: One commenter suggested that copayments and deductibles for families with incomes over 150 percent of the FPL be subject to the same limits that apply for families with incomes 101 to 150 percent of the FPL, noted in §457.555(a) and (b).

Response: The limitations proposed in §457.555(a) and (b) implement section 2103(e)(3)(A)(ii)of the Act. This section of the Act only applies to cost sharing imposed on targeted low-income children in families at or below 150 percent of the FPL. With respect to targeted low-income children in families above 150 percent of the FPL, the statute explicitly sets forth different cost-sharing provisions at 2103(e)(3)(B) and permits States to impose cost sharing that is only subject to the 5 percent cumulative cost-sharing maximum. Therefore, we do not have the statutory authority to apply these limits to cost sharing on children in families with incomes above 150 percent of the FPL.

Comment: One commenter encouraged HCFA to make the maximum allowable cost-sharing charges consistent with Medicaid. The commenter noted that a family with an income at or below 150 percent of the FPL enrolled in SCHIP has the same disposable income as a family with an income at or below 150 percent of the FPL in Medicaid, and therefore should not be expected to absorb a

higher cost-sharing limit. Also, in this commenter's view, because the family may move from one program to another, there should be consistency in cost sharing.

Another commenter stated that the cost-sharing limits in this section should have been based on the Medicaid maximums increased by the actual inflation experienced since the promulgation of the original Medicaid regulations.

Response: Section 2103(e)(3)(ii) of the Act limits the copayments, deductibles, or similar charges imposed under SCHIP, for families with incomes at or below 150 percent of the FPL, to Medicaid cost-sharing amounts "with such appropriate adjustments for inflation or other reasons as the Secretary determines to be reasonable." The cost-sharing amounts under Medicaid (found at 42 CFR 447.52) were originally established in regulation in 1976 and have never been adjusted for inflation. Therefore, using the discretion permitted under the statute, we inflated the schedule for SCHIP for cost sharing imposed on enrollees whose income is from 101 to 150 percent of the FPL. In doing so, we looked at both the general inflation rate and the level of need in the population at issue in reference to Medicaid recipients. Because children in families with incomes below the poverty line are more closely tied to the traditional Medicaid population, we have not inflated the Medicaid cost sharing limits found at §447.52 for SCHIP enrollees with incomes at or below 100 percent of the FPL.

We also note that under Medicaid, States cannot impose copayments, deductibles, and coinsurance on children under the age of 18. Therefore, children under the age of 18 who become eligible for the Medicaid program should not be subject to any copayments, deductibles or similar charges in accordance with §447.53 of the Medicaid regulations. The SCHIP statute, however, clearly contemplates and permits the application of cost-sharing to SCHIP enrollees.

Comment: One commenter supported the higher cost sharing for non-emergency use of the emergency room. The commenter believes in promoting the concept of the medical home and encouraging families to receive their children's care in that context.

Response: We appreciate the support of the commenter and also note that the policy, by only permitting twice the usual copayment amount for non-emergency use of the emergency room, protects the lower income populations served by SCHIP from having to pay excessive cost sharing if they find they can only access services at an emergency room. At the same time, it encourages enrollees to receive non-emergency services outside of an emergency room setting.

We realized that the proposed regulation text was not clear regarding the limit on cost sharing related to emergency services. Therefore, we added to section §457.555(a) that the

maximums provided in this section apply to non-institutional services provided to treat an emergency medical condition as well. We also clarified in paragraph(c) that any cost sharing the State imposes on services provided by an institution to treat an emergency medical condition may not exceed $5.00. Finally, we removed paragraph (d) from this section, because the requirement is already included in §457.515(f).

Comment: Several commenters were concerned about the language in §457.995(c)(2) which prohibits patients from being held responsible for any additional costs, beyond the copayment amount specified in the State plan, that are associated with emergency services provided by a facility that is not a participating provider in the enrollee's managed care network.

Response: With respect to the issue of additional costs for out-of-network emergency services, we believe that any costs associated with evaluating and stabilizing a patient in an out-of-network facility in a manner consistent with the cost-sharing restrictions in this regulation at §457.555(d) must be worked out between the State and the managed care entity. Given the nature of the circumstances that may necessitate emergency services, enrollees may not be able to choose their place of care. Thus, the regulations do not allow additional cost sharing to be imposed on the beneficiary for emergency services including those provided out-of-network as described in

§457.515(f)(1) of this final regulation.

Comment: Two commenters asked that we clarify the interpretation of the phrase at §457.555(a)(3) and (b) "directly or through a contract", with regard to payment made by the State. This commenter interpreted the phrase to mean that when the State operates SCHIP through employer-sponsored health plans, States would be expected to determine the rates paid by those health plans to hospitals and other providers and apply the standards cited in this section to determine allowable cost-sharing limits. The commenter asserted that, if this is HCFA's expectation, these requirements will make it difficult for States to implement SCHIP programs utilizing employer-sponsored health insurance since the State is not the purchaser of health care services in these cases and does not have a legal basis for accessing confidential or proprietary information, such as rates paid by plans to participating providers. The commenter recommended that States that use employer-sponsored insurance be exempt from the requirements proposed of §457.555(a)(3) and (b) since these requirements are likely to dissuade many employers from participating in SCHIP.

Response: Any State that contracts with another entity to provide health insurance coverage under the SCHIP program is paying for services through a contract. If a State subsidizes SCHIP coverage other than through a contract, such as in a

premium assistance program, the State is still responsible for ensuring that cost-sharing charges to enrollees in such plans comply with this regulation. We recognize that this might require some additional steps but it is important to provide these protections to all SCHIP enrollees uniformly. States, as part of any contract with a health insurer, should request the payment rate information to assure that cost sharing being imposed by the insurer does not exceed the amounts in this section. We are also revising §457.555(b) to specify that copayments for institutional services cannot exceed 50 percent of the payment the State would have made under the Medicaid fee-for-service system for the service on the first day of institutional care. As previously discussed, employer-sponsored insurance is subject to the same cost-sharing limits as all separate child health programs. This rule applies to both managed care and premium assistance programs.

Comment: One commenter urged HCFA to include language in the preamble to underscore that the philosophy and structure of managed care delivery systems make unnecessary the use of cost sharing to control utilization. HCFA should encourage States to set lower maximum allowable cost-sharing amounts for institutional services.

Response: States have discretion under 2103(e) to impose cost sharing up to the limits established in the statute and in

this regulation. We note that many studies have shown that cost sharing does impact utilization in managed care delivery systems. We also note that 50 percent of the cost of the first day of care in an institution may be expensive for families below 150 percent of the FPL. We encourage States to set reasonable limits that take into consideration the income level of these families.

Comment: One commenter supported limiting copayments per inpatient hospital admission, but noted that the current proposal is based on each institutional admission. In this commenter's view, this policy has the potential to promote early release and frequent readmissions that could be detrimental to a child's health. The commenter suggested that cost sharing for institutional admissions be based on a period of time or some other criteria in order to prevent potential inappropriate releases.

Response: Section 2103(e)(3)(A)(ii) limits the imposition of cost sharing to the nominal amounts consistent with regulations referred to in section 1916(a)(3) of the Act. Proposed §457.555(b) mirrors §447.54 of the Medicaid regulations regarding institutional services with some clarification for its application in the SCHIP context. We have not found data that supports a pattern of early discharge exists in the Medicaid program due to this provision. Therefore, we will adopt the regulation as proposed, consistent with section 2103(e)(3)(A)(ii)

of the Act.

Comment: One commenter indicated that, with regard to institutional services, the proposed regulation states that the cost sharing cannot exceed 50 percent of the payment the State makes directly or through contract for the first day of care in that institution. The commenter stated that, in a managed care context, the State does not pay a per day amount to the managed care entity (MCE). The commenter requested that HCFA clarify how this institutional cost-sharing limitation is to be interpreted in the MCE setting.

Response: We have clarified §457.555(b) to indicate that cost sharing may not exceed 50 percent of the payment the State would have made under the Medicaid fee-for-service system for the first day of care in that institution. We believe this remains consistent with the legislative intent to keep cost sharing at nominal levels in accordance with Medicaid.

Comment: One commenter observed that the imposition of copayments for emergency room visits that mirror copayments for other services, including physician or clinic visits ($5.00 copayment) provides a negative incentive. States should have the ability to impose a differential copayment for emergency visits, even if it is minimally higher than that imposed for visits to a primary health care provider.

A commenter stated that, in order to control non-emergency

utilization of the emergency room and to smooth the transition of families from SCHIP to commercial insurance coverage, States should be permitted flexibility in establishing the maximum copayment amount for such services and notes that, in some States, amounts up to $25.00 have been permissible. One commenter noted that without differential copayments for emergency room visits, the incentives are aligned to promote use of a primary care model over unimpeded access to emergency rooms.

Response: We have revised §457.555(a) of the final regulation to specifically require that services provided to an enrollee for treatment of an emergency medical condition shall be limited to the cost schedule under (a) of that section with its maximum of $5.00. We also note that States are not required to charge the maximum amount permitted in §457.555(a) for a physician service and may choose to impose a lower amount than $5.00 on physician services, providing the incentive for the beneficiary to access services at the physician level before using the emergency room. In addition, §457.555(c) permits a maximum amount of $10.00 for nonemergency use of the emergency room, which may also create incentives to use the primary health care provider when appropriate.

For the targeted low-income child in a family with income above 150 percent of the FPL, States may impose a higher amount than $5.00 for emergency services provided in an emergency room

as long as the family has not paid cost sharing that exceeds the cumulative cost-sharing maximum of 5 percent of the family's income for a year. The regulation only requires that States limit copayments for emergency services provided in the emergency room to the schedule in §457.555(a) for those children in families with income from 101 to 150 percent of the FPL, and limit such copayments consistent with §457.540(b) for those children in families with incomes below 100 percent of the FPL.

Comment: A commenter recommended that no arbitrary amount ($10.00) be used as the maximum copayment for non-emergency use of the emergency room. In this commenter's view, if such an amount is included in this section, it should be indexed for inflation.

Response: The maximum copayment amount is based on the statutory requirement that cost sharing for families at or below 150 percent of the FPL must be in accordance with the Medicaid rules. The amount of $10.00 in §457.555(c) is consistent with §447.54(b), which allows a waiver of the nominal amount in the Medicaid regulation for nonemergency services furnished in a hospital emergency room up to double the maximum copayment amounts. We have chosen a set limit for the SCHIP enrollees in families with income from 101 to 150 percent of the FPL in lieu of the complicated waiver requirement in Medicaid.

Comment: A commenter agreed that non-emergency use of

emergency facilities should be limited. However, the commenter is concerned about doubling the noninstitutional copayment amount permitted when an enrollee uses an emergency room for non-emergency services. The commenter noted that, in many rural areas, access to non-emergency facilities may not be readily available, and argued that families should not be penalized (charged double) when alternative services are not available.

Response: Proposed §457.735 (now §457.495) of the regulation requires the State plan to include a description of the methods it uses for assuring the quality and appropriateness of care provided with respect to access to covered services. States must ensure that an adequate number of providers available so families do not need to seek routine treatment in an emergency room.

Comment: Several commenters asked that the regulation clarify that States should use the prudent layperson standard proposed at §457.402(b) in the assurance that cost sharing for emergency services to managed care enrollees would not differ based on whether the provider was in the managed care network.

Response: We agree that the prudent layperson standard should be applied to this section. In the proposed rule, we defined emergency services at §457.402(c), to include the evaluation or stabilization of an emergency medical condition. Because this definition is relevant to the entire regulation, we

have moved the definitions of emergency services and emergency medical condition to §457.10. Section 457.10 now defines emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in jeopardizing the individual's health (or in the case of pregnant women, the health of the woman or her unborn child), serious impairment of bodily function or serious dysfunction of any bodily organ or part.

Comment: One commenter suggested that HCFA issue additional guidance on what, if any, sanctions for non-payment of cost sharing can be exercised.

Response: States are allowed flexibility when proposing sanctions. HCFA will review the State sanctions as part of the State plan and consider proposed sanctions on a case-by-case basis. We will require that States, in accordance with §457.570(b), provide an opportunity for the targeted low-income child's family to have its income reevaluated when the family cannot meet its cost-sharing obligations. The family income may have dropped to a point where the child qualifies for Medicaid, or where the child is in the category of SCHIP enrollees that is subject to lower (or no) cost sharing.

13. Cumulative cost-sharing maximum (§457.560).

Section 2103(e)(3)(B) of the Act provides that any premiums, deductibles, cost sharing or similar charges imposed on targeted low-income children in families above 150 percent of the FPL may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing with respect to all targeted low-income children in a family may not exceed 5 percent of the family's income for the year involved. We refer to this cap on total cost sharing as the cumulative cost-sharing maximum.

We proposed two general rules regarding the cumulative cost-sharing maximums. First, a State may establish a lower cumulative cost-sharing maximum than those specified in §457.560(c) and (d). Second, a State must count cost-sharing amounts that the family has a legal obligation to pay when computing whether a family has met the cumulative cost-sharing maximum. We proposed to define the term "legal obligation" in this context as liability to pay amounts a provider actually charges the family and any other amounts for which payment is required under applicable State law for covered services to eligible children, even if the family never pays those amounts.

We proposed that for children in families above 150 percent of the FPL, the plan may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate exceed 5 percent of total family income for a year (or 12 month eligibility period).

We proposed that for targeted low-income children in families at or below 150 percent of the FPL, the plan may not impose premiums, deductibles, copayments, co-insurance, enrollment fees or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period.

Comment: A number of commenters disagreed with the proposed definition of "legal obligation" for use in connection with counting cost-sharing amounts against the cumulative cost-sharing maximum. They noted that it is very difficult and time-consuming to track payments that have not occurred. One commenter suggested changing the definition of the term "legal obligation" to only those "cost-sharing amounts, which families have actually paid."

Response: States may rely on documentation based upon provider bills that indicate the enrollee's share rather than relying only on evidence of payments made by the enrollee. We have not adopted the commenters' suggestion because this could result in families being legally obligated to pay cost-sharing amounts in excess of the cumulative maximum.

Comment: One commenter asked if this provision means that for any and all out-of-network health services, (provider charges in excess of the amount paid by the health plan) must count toward the family's cumulative cost-sharing maximum. The

commenter noted that no private health plans work this way, especially employer-sponsored plans. According to this commenter, a requirement to recognize out-of-network provider charges would greatly complicate this process by requiring States to verify that provider bills submitted by families as evidence of having reached the maximum were not in fact paid by the health plan in which the children are enrolled.

Response: If an enrollee has been authorized by his or her health plan to receive out-of-network services, then the associated charges must comply with these rules and be counted toward the cumulative cost-sharing maximum. In addition, an enrollee's costs incurred for emergency services (as defined at §457.10) furnished at an out-of-network provider also count toward the cumulative cost-sharing maximum. The regulation does not require coverage of out-of-network services that are not authorized, except for emergency services. Therefore, States are not required to count costs of unauthorized services received out-of-network toward the cumulative cost-sharing maximum.

Comment: One commenter recommended that States be able to retain the flexibility to define the year for purposes of cost sharing as the insurance benefit year for group insurance rather than an individual family's eligibility period as proposed. In this commenter's view, the use of individual family eligibility periods would be an ?administrative nightmare".

Response: States may apply the cumulative cost-sharing limits based on the insurance benefit's 12 month period for group insurance. In that case, for families that enroll during the benefit year, the State must calculate the cumulative cost-sharing maximum based on the income of the family only for the period of time the beneficiary is actually enrolled within that benefit year.

Comment: One commenter noted that these rules allow a State to count cost-sharing amounts that the family has a legal obligation to pay. The commenter indicated that as section 330 Public Health Service grantees, Federally qualified health care centers (FQHCs) are required to prepare a schedule of fees or payments for incomes at or below those set forth in the most recent FPL. They also noted that health centers are obligated to charge patients on a sliding scale basis if their income is between 100 and 200 percent of the FPL. Therefore, the commenter stated that, based on this proposed rule, health center patients will not receive cost-sharing credits for that portion of the copayments that the health center is expected to waive under a sliding fee schedule policy.

The commenter requested that HCFA provide an exception to consider SCHIP patients served in FQHCs as having paid the full highest possible copay cost of the copayment in calculating the cumulative cost-sharing maximum, whether or not they were charged

this amount. In addition, the commenter indicated that SCHIP plans should be instructed that, if a FQHC normally charges its patients with incomes between 100 and 200 percent of the FPL on a sliding scale basis, it should not be required or expected to apply a cost-sharing charge to a SCHIP patient that would exceed its sliding scale discount. For example, if the health center charge for a service is $100.00, but it only charges $50.00 for those with incomes between 150 percent and 200 percent of the FPL, it should only charge 50 percent of the allowable copayment for patients covered under SCHIP, in this commenter's view.

Response: States are only obligated to count towards the cumulative cost-sharing maximum the amounts that a patient has a legal obligation to pay. Therefore, States may not count the amounts that the health center covers towards the maximum. The State is only obligated to count what the SCHIP patient is actually charged by the health center for purposes of the cumulative cost-sharing maximum. However, we do agree that the FQHC should not charge the enrollee more than is permissible under the FQHC's sliding scale, nor should it charge the enrollee more than is permissible under the SCHIP program.

Comment: Several commenters requested that we reconsider the 2.5 percent cumulative cost-sharing maximum. They raised specific concerns regarding the 2.5 percent cumulative cost-sharing maximum, including: The provision is not supported by

the statute; it is very difficult to administer two caps (2.5 percent and 5 percent) and track against two caps; limits on copayments and deductibles are already found in §457.555 and section 2103(e)(3)(A) of the Act; States have already implemented flat cumulative cost-sharing maximums that are administratively efficient and provide families with fluctuating incomes greater stability; HCFA's commissioned study by George Washington clearly demonstrates that it is rare that enrollees will reach the 5 percent cost-sharing maximum; and when a limit is set using a percentage, there is no need to make the percentage less.

One of the commenters also noted that the Medicaid maximum charges for premiums and other cost-sharing charges, which apply to families at or below 150 percent of the FPL, are minimal in amount and are not based upon income or family size. As a result, the addition of another level of cost sharing (2.5 percent) adds to an already complex cost-sharing structure, in this commenter's view. The commenter added that such requirements are virtually impossible to implement in a program that subsidizes employer sponsored insurance.

Response: We disagree with the commenters. A lower cost-sharing maximum on children is necessary in order for States to comply with the requirements at section 2103(e)(2)(B), which require that separate child health plans may only vary cost sharing based on the family income of targeted low-income

children in a manner that does not favor children in families with higher incomes over children in families with lower incomes. If the State does not want to administer two caps, it does have the option to place the 2.5 percent cap or a flat amount equal to 2.5 percent of the family's income on the entire enrollee population that is subject to cost sharing. This should have a minimal impact on the amount of cost sharing States will impose; particularly in light of the George Washington University study, as indicated by the commenter, which found that it is rare for families to reach the 5 percent cap at all. The State may also choose to impose premiums instead of copayments, coinsurance or deductibles, so that tracking of cost sharing is not necessary.

Comment: One commenter noted that the separate calculation requirement applied to each beneficiary's family to ensure that the five percent cost-sharing limitation is met is unwieldy and expensive. In this commenter's view, it is unlikely that opportunities for participation in premium assistance programs will be aggressively pursued. The commenter also asserted that our policy eliminates the opportunity for children in SCHIP to be enrolled in premium assistance programs.

Response: For targeted-low income children in families with income greater than 150 percent of the FPL, section 2103(e)(3)(B) requires States to ensure that cost sharing does not exceed 5 percent of a family's income. The statute does not exempt States

from this cap if they provide child health assistance through an employer-sponsored insurance program. Therefore, we have not included any exceptions to the rules for States utilizing premium assistance programs.

Comment: One commenter stated that the regulation goes beyond legislative intent by requiring that copayments and deductibles be included in the computation of the maximum cost sharing for a family with income above 150 percent of the FPL. In support of this point, the commenter noted that section 2103(e)(3)(B) of the Social Security Act limits "enrollment fees, premiums, or similar charges" to five percent of the family's income. The commenter asserted that deductibles and copayments are not "similar charges," because they are not prepayments for benefits coverage; rather, they are payments made to treating providers at the time of service delivery. By requiring States to include deductibles and copayments in the calculation of the maximum, HCFA has created major administrative problems, especially for the majority of states that are using HMOs or other insurers in this commenter's view. The commenter recommended that we limit the calculation of the maximum amount to "enrollment fees, premiums and similar charges". The State merely has to make sure it sets a premium below the maximum of 5 percent of family income.

Response: Section 2103(e)(3)(B) of the Act provides that

"any premiums, deductibles, cost sharing, or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing with respect to all targeted low-income children in a family under this title may not exceed five percent of such family's income for the year involved." The statute's reference to "deductibles, cost sharing, and similar fees" clearly indicates that the charges to be counted towards the cumulative cost-sharing maximum are not to be limited to premiums and enrollment fees. However, States have the option to impose only premiums under their SCHIP plans.

Comment: One commenter noted an error in this section. Specifically, the commenter pointed out that the proposed regulation text states that total cost sharing imposed on families with incomes above 150 percent of the FPL not exceed the maximum permitted under §457.555(c). It should be §457.560(c).

Response: The commenter is correct that the reference should have been to §457.560(c). In addition, in order to eliminate this confusion and redundancy in the final regulation text, we have eliminated section §457.545 and reflected the policy at §457.560(c).

14. Grievances and appeals (§457.565).

We proposed that the State must provide enrollees in a separate child health plan the right to file grievances and

appeals in accordance with proposed §457.985 for disenrollment from the program due to failure to pay cost sharing. We address comments on proposed §457.565 in subpart K, Enrollee Protections, which now contains the provisions relating to applicant and enrollee protections. We have deleted proposed §457.565 in an effort to consolidate all provisions relating to the review process in the new subpart K.

15. Disenrollment protections (§457.570).

Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Based upon this provision of the statute, we proposed in §457.570 to require that States establish a process that gives enrollees reasonable notice of, and an opportunity to pay, past due cost-sharing amounts (premiums, copayments, coinsurance, deductibles and similar fees) prior to disenrollment. We requested comments on this requirement, including specific comments on the determination of an amount of time that would give enrollees reasonable notice and opportunity to pay cost-sharing amounts prior to disenrollment. We stated that we would request that States with approved plans submit this additional information after publication of the proposed rule

and prior to the State's onsite review. We stated that we would also ask the State to include a description of its process in future amendments to its State plan.

Comment: One commenter noted that disenrollment occurs in the Hispanic population because the SCHIP process is extremely paper-intensive. In this commenter's view, one of the most common reasons for disenrollment from SCHIP is the termination of benefits due to the failure to provide premium payments in a timely manner. They stated that, Hispanics in eligible income brackets, in particular, tend to deal in a cash economy, making it difficult to pay SCHIP premiums in the preferred method of payment. In order to slow disenrollment the commenter stated that it is necessary to devise a plan to eliminate the barrier to payment, and effectively reduce the rate of disenrollment among Hispanics.

Response: The SCHIP statute specifically allows States to impose premiums on the SCHIP population within statutorily defined limits. However, we encourage States to be flexible in the methods of payment permitted for cost-sharing charges and to allow grace periods and to provide adequate notice when payments are not made. We have clarified in the final rule that the State plan must describe the disenrollment protections provided to enrollees. In addition, States might monitor disenrollments by reason for disenrollment and determine whether certain groups of

enrollees are more likely than others to lose coverage due to failure to meet the cost-sharing requirements. In addition, we encourage States to work with advocates from the Hispanic community to devise culturally sensitive methods to inform consumers about cost sharing and devise appropriate procedures for obtaining necessary premium payments.

Comment: One commenter noted that the appeals procedures should not be structured in such a way as to give a child's family an incentive to drop SCHIP coverage for a child until he or she needs health services. This practice undermines basic insurance principles and threatens the financial integrity of SCHIP programs because it would result in the pool of enrollees being significantly more sick and more costly than would otherwise be anticipated, in this commenter's view. They stated that the result of such a practice would be to unnecessarily increase the costs of providing coverage to enrollees, which in turn would potentially threaten the viability of the State's SCHIP. The commenter recommended that HCFA revise the regulation to require States to address this issue when they define the circumstances under which a member will be permitted to re-enroll following voluntary disenrollment or disenrollment for nonpayment of premiums or cost sharing.

Response: We are aware that there may be problems when an enrollee is disenrolled and permitted to re-enroll. Some States

have adopted lock-out periods to promote the appropriate utilization of health insurance, although other States have discontinued their lock-out periods because they did not find any significant increase in sicker enrollees. States have the flexibility to design their programs based on their unique circumstances to assure that eligible enrollees maintain coverage.

Comment: Many commenters agreed that enrollees should be given an opportunity to pay past due cost sharing prior to disenrollment. Many commenters noted that there should not be any lock-out periods, that States should give families every opportunity to pay past due premiums and at a minimum, grant grace periods of 60 days for the non-payment of premiums. One commenter suggested that the preamble urge States to conduct a Medicaid screen if a child's family is unable to pay premiums due to financial hardship.

Response: We agree that, at the very least, a State should give enrollees a chance to pay past due cost sharing prior to disenrollment. While many commenters noted that lock-out periods should not apply, it is appropriate to allow States to implement a lock-out period so that individuals are not obtaining or maintaining SCHIP coverage only when they need services. We also agree with the comment encouraging States to perform a Medicaid eligibility screen for enrollees who are unable to pay cost-

sharing charges due to financial hardship and have emphasized this elsewhere in comments to this final rule. We have added that the disenrollment process must afford enrollees the opportunity to show that their family income has declined prior to being disenrolled for nonpayment of cost-sharing charges. In the event that such a showing indicates that the enrollee may have become eligible for Medicaid or a lower level of cost sharing under separate child health plans, States should take action to either enroll the child in Medicaid or adjust the child's cost sharing category. We expect this new protection will afford enrollees the opportunity to enroll in Medicaid if they have become eligible.

Comment: A few commenters noted specific standards regarding disenrollment protections that HCFA should articulate in the final regulation. Specifically, the commenter recommended that HCFA clearly define what constitutes reasonable notice; clarify that only the State may disenroll a child or impose any other sanction due to an enrollees's failure to pay cost sharing; provide that disenrollment can only be effected after all reasonable steps have been undertaken to avoid disenrollment; require that families should be offered the opportunity to establish a repayment plan; and that families cannot be subjected to penalties or interest for past due payments.

Response: The regulation at §457.570 regarding

disenrollment protections provides enrollees with meaningful protections in connection with any disenrollment related to cost sharing while giving the States flexibility to establish processes consistent with the goals and structure of their programs. We do not accept the commenter's recommendation that HCFA be prescriptive in the regulation regarding disenrollment protections, because each State's SCHIP program is separate and distinct and should retain flexibility accordingly.

Comment: One commenter noted that States should be given the flexibility to decide how they will implement this standard. Specifically, this commenter believes it is administratively burdensome to track a specific grace period before a family is disenrolled from SCHIP.

Response: States are granted flexibility to establish disenrollment procedures under §457.570 of the final rule. These procedures must be included as part of the State plan. However, the rule does require States to provide reasonable notice prior to disenrollment and provides for a period of time (grace period) for the enrollee's family to pay past due amounts. The rule also enables the State to evaluate the enrollee's financial situation prior to disenrollment to ensure he or she does not qualify for Medicaid.

Comment: One commenter complained that the proposed disenrollment protections were too burdensome because they do not

permit disenrollment for nonpayment of premiums even after reminder notices have been sent. One commenter noted that implementing a grace period before disenrollment will result in duplicative coverage and wasted funding since research shows that the primary reason a family fails to pay its monthly premium is that the family has obtained other coverage.

Response: The regulation at §457.570 regarding disenrollment protections gives the States flexibility to establish processes consistent with the goals and structures of their programs. A disenrollment process without any grace period could result in a system that would disenroll a family prematurely (without adequate notice) and interrupt the family's continuity of care. Therefore, we continue to require that States establish a process that gives enrollees reasonable notice of, and an opportunity to pay past due premiums, copayments, coinsurance, deductibles, or similar fees prior to disenrollment.

Comment: One commenter noted that there may be cases in which the individual responsible for paying a premium is not the custodial party or head of household for the children. In such cases, the commenter stated that notices of disenrollment for failure to pay a premium need to be provided to both the payer of the premiums and the SCHIP beneficiary. Also, if premiums are owed by an individual other than the head of household, and are not paid, the family receiving the SCHIP benefits should not be

subject to penalties, and should be given an opportunity to assume responsibility for making future payments.

Response: We agree with the commenter and recommend that States review all viable financial options of an enrollee prior to disenrolling an enrollee due to a parent or caretaker's failure to pay cost sharing. We will also require that States include a disenrollment policy as part of its public schedule, so that all family members who are responsible for paying cost sharing on behalf of the enrollee are informed of the disenrollment process.